UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

OLUX FOAM (clobetasol propionate)

Patient name:_____Medicaid or SS# _____

Physician Name:_____Contact person:_____

Phone#:_____Ext. and opt._____ Fax#_____

Pharmacy_____Pharmacy Phone#:_____

All information to be legible, complete and correct or form will be returned

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FAX DOCUMENTATION FROM PROGRESS NOTES

CRITERIA:

DOCUMENTED failure on generic formulations of Clobetasol Propionate creams, ointments, or solutions within the last 12 months.

AUTHORIZATION:

6 months

RE-AUTHORIZATION:

Telephone request from physician's office or pharmacy